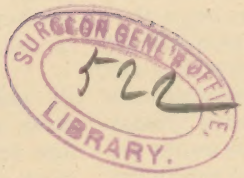
PRICE (JOS)

Motive, preparation and results in abdominal and pelvic surgery.



PRICE (Jos.)

Reprinted from the MEDICAL AND SURGICAL REPORTER, December 31st, 1892.

MOTIVE, PREPARATION AND RESULTS IN ABDOMINAL AND PELVIC SURGERY.

BY JOSEPH PRICE, A. M., M. D.

My motive in coming here is not so much to impart as to gain information. I know the value of contact, of close and intimate association with the zealous working men of the profession. Our talks, generally, have much that is very crude in them for which we need not pause to apologize.

There is a growing conviction in the profession that every surgeon must stand on his own legs. In medicine and surgery there are no Blue Laws—no geography fixing the limits of advances. There will always be a pressing need to make our science and art better. There is not much in that physician or surgeon who is content with his little store of scientific knowledge, with the results of his observations and experiences however extended and successful. He would serve better in redeeming some old sedge field to productive agriculture than in the field of medicine and surgery. Those men learn most who feel most the gravity of their responsibilities, the issues involved in their work; and who zealously seek through every avenue of observation, investigation and research for that knowledge and art, those combined agencies, which will make their work the more successful.

Many of our countrymen travel from the extreme borders of our forty-four commonwealths to our medicalcentres for the lessons they can gain in laboratories, hospitals, and public and private clinics. This spirit of improvement promises much for the future of medicine and surgery. It would be very discouraging to feel that our present surgery could not be out-done. The tendency is to break away from all traditions, rules-of-the-thumb maxims,—to drop all reverence for fossil immutability, for medical antiques, the bric-brac and mummies of ancestral chimney corners,—the preference is rather to do with that which is alive and promises life than with a carcass.

It is growing to be better recognized that the clearness with which the surgeon sees, the skill with which he works must come of accumulated experiences. We have a rapidly growing army of laboratory workers whose researches are making rich contributions to modern science, many of the men working with all the enthusiasm and energy of the old chemists. There is more grit and energy in the young of the profession than has ever characterized any previous period in the history of the profession. The old veterans are along with them with a youthful warmth of fellowship, and there is nerve and inspiration in their elbow touch. Wide series of researches have been called into life, directed by many along specific lines, and the more specialistic press upon our notice. These researches are evolving definite ideas from conflicting theories. So many are the kinds of work and kinds of workers that the laity are puzzled where to go and to whom with their special afflictions.

In this particular there is no very special harmony of opinion among physicians. Though a life is involved their better professional judgments are often overcrowded by personal prejudice, likes or dislikes. There is not enough of clean, clear, active working of professional conscience. There is something of appropriate illustration of this spirit in the hospital science drawn by the witty German, Henry Heine: "They remind me of a revolting quarrel, in a little hospital at Cracow, of

which I chanced to be a witness, and where it was horrible to hear how the patients mockingly reproached each other with their infirmities; how one who was wasted by consumption jeered at another who was bloated by dropsy; how one laughed at another's cancer in the nose, and this one again at his neighbor's lockjaw or squint, until at last the delirious fever-patient sprang out of bed and tore away the coverings from the wounded bodies of his companions, and nothing was to be seen but hideous misery."

Reckless ignorance, unreasoning jealousy, professional vanity, a narrow envious rivalry often goes on, insolently refusing counsel, until when the coverings are removed nothing is to be seen but hideous misery. The profession would not be impoverished by expelling all men with such low-governing motives, nor would humanity suffer.

In relation to surgery, the least experienced, the more ignorant are the ones who talk the most about the ethics of operative procedures, and even after they have failed in palliative treatment, exhausted their therapeutical resources they oppose resort to surgery. From this blindness, this narrowness, there will be an awakening. Fortunately this spirit grows beautifully less as the profession liberalizes under the influences of our advances. The notoriety of these characters renders their company of easy avoidance.

There is a certain justifiable antagonism between the honest, educated, conscientious general practitioner and the specialists of a certain class. There could not be, nor should there be, good feeling for that officious class who find fault with, and unsolicited, interfere with prescribed treatment. It is not by knowledge and skill such men sustain themselves, but by artifice, by undermining more worthy and better men. To them medicine and surgery are not learned, high-toned, dignified professions—but trades, marts, into which they can go with their wares and practice their damaging acts for the little, or much ready cash, they can command; their only credentials to recognition are their audacity and insolence.

The professional spirit of the period is not one of mimicy. It is not mortgaged to old ideas and methods. Innovations are welcomed; that only is accepted as tested truth which has withstood the severest processes of verification. We honor the man who confronts us with an honest difference of opinion; he may have much for us we need to know. I will greet him as my hero friend, if he, with his better light, will supplant my methods with his better ones, and I would have my patients send him greeting.

Both in medicine and surgery the line between enough and too much is becoming better understood. It is realized that the physician's resources are exhaustless — that they are co-extensive with the limitless field of medical science; that the highest honor of the profession is the cumulative culture, refinement and success of its individual members; that every growth and success of the individual physician is the honest advantage of all. We all must feel again and again the pain and mortification of imperfect work. We prefer to take the great workers, those working unremittingly to master the puzzling problems, as types or representatives of the best spirit of the profession.

There may be some barriers to the free use of some of our educational agencies, but they *can* and *will* be broken down. We will have more free, liberal and better teaching within the walls of our public hospitals, where ministers our public and private charities to the unfortunate victims of accident and disease; from their bedsides we *will have* the lessons that will advance our science and improve out art. We *will* batter at the doors until they *open*, or *down*, and let us in. The spirit that will gladly welcome will be substituted for the narrow and selfish one that bars us out. We are entitled to be present witnesses of those maladies with which it is our life mission to deal. There general practitioners can gain valuable lessons,—and it is in their ranks every successful specialist in the profession must have his beginning,—and there the honest, enthusiastic student of a specialism can the more thoroughly equip himself for his work.

Where the specialist in gynecology, or in any special line of surgery, attempts to give practical training it will be used against him by his professional rivals, who will try to secure patients by saying to them, "If you go to Dr. Blank he will have his students do the operation; he won't do it himself." This fact operates against practical training in private hospi-

tals. But no such excuse exists against such training in public or general hospitals. The thorough education of physicians, the health and happiness of multitudes of unfortunate human beings, demand that the lessons of the operating table and bedsides of these institutions should be the privilege of every physician and surgeon. That man does the most effective teaching who does it with his apron on. We cannot multiply to too great an extent the avenues through which we can obtain the highest education in our science, in the methods of the best surgical procedures, in the refinements of their technique. From every patient we attend there comes to us the urgent bidding, "give us the benefit of your best science, your most perfected methods for our healing."

I would press these facts home, for it is the voice of the profession that will bring about this important gain in our educational facilities. By the rights of that humanity it is our high duty to serve, I have a right to the benefit of what you know and you have a right to the lessons of my experiences, down to the simplest teachings of the cunning of my fingers.

A little aside from logical connection I would say that there is no self-mortification or shame in recognizing our individual professional limitations. When a member of my own family is sick, an early experience in general practice enables me to detect symptoms and locate the trouble, but I am prompt to call in a physician of known reputation for the treatment, an expert in the peculiar trouble, and the case is left as absolutely to him for treatment, as I insist upon in cases coming into my hands for surgical treatment. We can only stand, professionally, on the highest elevation when all the purely selfish elements are eliminated.

The inevitable risk in all cases, is that while the physician is being whirled around in a circle of doubts, symptoms are augmenting, the disease becoming more aggravated and the chances of relieving suffering and saving life growing less. Happily the profession is growing alive to these facts.

We are forced to keep in advance of the intelligence coming out from our free schools—I don't like the word common. Our clientele is demanding more and better work than was ever before demanded. Our specialisms are largely an outgrowth of this demand. In many instances the general practitioner tires of an extended and exacting practice, as he finds it wears upon his vitality. Necessity presses upon him to restrict its limits and he turns to some speciality in which his tastes and aptitudes promise success. Combining the training of his general experience with a careful and thorough training in the speciality of his selection, successful work is assured. He will hold high and honored place in his speciality—will make a record, and that not of a startling mortality. Not so with that noble possibility in embryo, the fresh graduate from our colleges, with his fashionable droop of the shoulders, bend of the elbows and knock of knees, and his one glove, who, immediately on receiving his diploma, essays to enter these fields with only his superficial theoretical knowledge, while he is scarcely prepared to do general work.

The need of the student is a hospital training, followed by dispensary practice, where he will become familiar with physical examinations and learn to recognize disease with varied forms. No one has a right to attempt the treatment of the diseases of women until he is educated to recognize and differentiate them.

Women would be better off if some of the so-called minor gynecological procedures had never been devised. Some operations and instruments in the hands of inexperienced and ill-trained hands are doing thrice more harm than good. It is alarming to note the number of serious major gynecological operations following closure or dilatation of cervix, also the inconsiderate use of the curette in the presence of advanced tubal and ovarian disease, or for the fancied existence of intra-uterine troubles, or as a therapeutic measure for a trouble lying beyond and unrecognized.

If it were possible to ascertain all the images called up to the inexperienced by the term abdominal surgery we would have a medley of conceptions as to such operations. The layman's views are very horrifying to him—to the poor woman, with whom we have to directly deal, they are not less so. We approach them, not with timidity, for that is not an element in the character of the surgeon, but with a very keen appreciation of the weighty responsibility involved, with a quick sense of the profes-

sional conscience, surgical judgment and skill needed to deal with those calamitous troubles to which women are subject. The woman, in the major cases, comes to us and uncovers "her hideous misery"—one perhaps concealed for years from a morbid sense of delicacy, or yet more likely and more frequently occurring where radical remedial treatment has been delayed through the tinkering and counsel of the attending physician. The specialist is very often her last resort. She goes to him in her desperation with her special trouble, when suffering has rendered her useless, life scarcely worth living, general health broken, weighed down by fears and many painful disappointments; with but one feeble hope clinging by delicate thread to precarious conditions. And then as she lies prostrate, disarmed, helpless, under our anæsthesia, there goes out from her a mute appeal to the highest motive that can govern in our surgery. It is, that by all the sanctities, there shall, unselfishly and devotedly, be rendered her the best service of trained judgments and skilled hands.

To be fit for this work the surgeon should clearly recognize the possible complex conditions lying concealed. His understanding of the organism of the parts with which he deals and their functions should be as nearly perfect as lies within human limitations, and this is possible only to the one who patiently investigates until he finds the truth. The great old scientist, Agassiz, could by a bone, detect a fish belonging to an extinct species; his thorough knowledge of the organic structure enabled him to know the parts.

In abdominal surgery, in fact in all surgery, there are important requirements and conditions auxiliary to judicious surgical treatment and success. The utmost care should be exercised in making all the patients' surroundings, in minutest detail, the very best. There should be cleanliness from the cellar floors to the escape pipe in the roof. There is no chemistry that will prevail against uncleanliness and slovenliness either in person or surroundings. Cleanliness, ventilation and dryness are the proper deoderizers of houses. The best precaution against all forms of dirt and dust collection is water, soap, brush, will and muscle. Their free and unremitting use, are the sure antiseptic against filth infections. Impure water is a sure conveyance of infectious poisons into the human body. All about there should be an atmosphere of purity, simplicity and cheerfulness. There is something very depressing, even to the well and healthy, in the gloom of surroundings. These sanitary and other precautions will not be carried out except under the most rigid surveillance of the surgeon himself. I presume I am not as well up in the Bible as my friends of Missouri and Kansas, but I thoroughly believe, indeed, know that the truth of the scriptural injunction, "Cleanliness is next to Godliness," is confirmed by the logic of every surgeon's experience. We insist upon the perfection of arrangements of sewerage, and scavenage, and a pure water supply for the prevention of filth diseases, while we often have offensive matter on or about our persons which water, soap and brush would remove. I would start with cleanliness, keep it up and end with it in my practice in obstetrics and in your practice. My practice in surgery and your practice, general or special, is worse than useless without it.

It is difficult to impress upon local sanitary authorities the terrible consequences of filth infections. It is sometimes only the noise of the dead carts and the activity of undertakers that awakes them to activity. It is only when filth diseases become mythically epidemic that they so far forget their despicable local politics as to pay attention to those sanitary matters which concern the welfare of the entire community in which they live and of which they are part. The continuous inflow into office receives more attention at their hands, than the continuous outflow of decaying refuse and infectious matters. The effect of such criminal neglect can not be represented in numbers, the diseased are not reckoned in the long roll of mortality.

The nurse should be the very impersonation and perfection of cleanliness, and not an animated lump of dirt and grease; she should be intelligent, quick and full of resource in emergencies; cheerful and amiable of disposition, not inclined to depression and moping. She should not be in love, except with her work. She should have great tact in dealing with patients, be quick to detect and adapt herself to peculiarities of dispo-

sition, even to those of the congenital shrew, combining with all great decision, coolness, nerve, kindness and gentleness. The expert, trustworthy and pains-taking nurse is invaluable to the surgeon; she relieves him of many anxieties and multiplies the chances of the patients recovery.

This rigid regime carried into our obstetrics would secure better general results than have heretofore been secured. The standard of proficiency of those attending through the critical period of child-bed cannot be made too high. We all know the damage and suffering caused by ignorance at this period. Ignorance nor any form of uncleaness should be tolerated within the sacred precincts of the child-bed chamber. These cases are often trusted to the care of women without the slightest education or preparation for this all important work, often women who are not capable of deciding in any given case whether the labor is natural or otherwise. Knowing the sequela, the terrible results of the ignorance of midwives, we take the high ground that mother and child should have the benefit of a trained nurse where such is possible, and of an experienced practitioner and obstetrician.

It, perhaps, is fortunate for us that we have no record of the terrible mortality of midwives—of the death and desolation their ignorance has carried into homes. In obstetrics our mortality should be about *nil.* I will refrain from discussing any of the muted questions in obstetrical practice. In the language of the grand old autocrat of the profession: "No man makes a quarrel with me over the counterpane that covers a mother with her new-born infant at her breast," and there may be something prophetic in his strong words that in a near future an enlightened public will have a "grand jury to bring in a bill against a physician who switches off a score of women, one after another along his private track, when he knows that there is a black gulf at the end of it, down which they are to plunge, while the great highway is clear."

There is one peculiar species of nurses I would not recommend to your favor. I would not recommend the selection, as nurse, of one who approaches the bedside and, gently stroking the patient's forehead, says, "My dear allow me to soothe your pathway to the grave. It would make me very happy to deliver any little last messages you may desire to leave behind for your friends. I hope you have arranged matters so as to feel reconciled to go." A nurse of this character exercises a rather melancholy influence. Too large a corps of nurses tends to confusion and is not favorable to good work. The number in attendance upon the operator should be limited to two, with perfect knowledge of his methods, and alert in anticipation of all his wants, and at no time should there be shadow of varying from his directions.

The most scrupulous care should be exercised in preparation of the patient for operation. One solution of the distressing mortality, following the work of some men, comes of careless preparation of the patient and neglected or bad nursing and after treatment.

Commonly the treatment begins in opium and stimulants and ends in opium and stimulants and a death certificate. Unfortunately some men are still at work using opium and commemning the use of the drainage tube. Comparing the crude imperfect methods of early operators we have a very satisfactory explanation of the causes of their startling mortality. Early in the history of ovariotomy the mortality ranged from twenty-four to seventy per cent.; now it varies from *nil,* in the hands of a few operators, to fifteen per cent. Careful and thorough preparation and qualification for this work, improvement and refinement in methods, accounts for this very marked reduction of mortality. Those with the highest percentage of mortality are of that class who began the study and practice of their surgery in the peritoneal cavity, with no other preliminary experience, probably, than that of having vaccinated a baby, and without that varied practical knowledge of general surgery essential to success in this special line.

To the inquiry, who should do abdominal work, there can be but one answer: The one who has served an apprenticeship and who knows where, when and how. The study of methods and technique by those ambitious to enter the field of gynecology, does not recieve that attention its importance demands. It is approaching close to the end of a century since the first ovariotomy was done; the methods and technique then were about the same as now; the procedure nearly as

perfect, and now it may be regarded as established. Then, as now, the pedicle was ligated and dropped. A number of American operators use the ligature and drop the pedicle. Dunlap, of Ohio, never used the clamps in a long series of operations.

The man who attempts this work should be quick, yet of deliberate decision. There should be no vibrating between conflicting opinions. He should possess skill of manipulation—a finger education. He should have a clear knowledge of planes of cleavage to be followed in enucleations. In these operations there should be no dancing about in uncertain efforts; a studied procedure will give a wealth of resource to fall back upon while dealing with troubles uncertain in character, relation and fixation to adjacent visara.

Surgery is not one of the dilettante sciences, nor one of rude medicinal art. It is best illustrated by masterly, civil engineering.

I will pass, in hurried and brief review, a few of our procedures. To do hysterectomy successfully, it is, first, of vital importance to learn how to make a pedicle. Second, how to treat it after it has been made. This once understood, the operator will have but little trouble with his patients and but few deaths. In a series of one hundred hysterectomies I lost six, three malignant and hopeless; two were pyæmic long before the operation, and one I lost by bad surgery. I will not here go into the history of treatment of the pedicle.

The removal of a simple cystoma is one of the simpliest of operations in surgery, a short incision, withdrawal of fluid, and sac; tying the pedicle and closure of incision by a few sutures, is a safe and simple procedure. But the removal of adherent or ruptured cystoma, or a suppurating cystoma with a twisted pedicle, a suppurating dermoid with universal adhesions, require some surgical judgement and skill. This complicated group requires painstaking enucleation for separation of all adhesions, careful examination and repair of all adherent and injuried viscera. In suppurating forms of pelvic and abdominal disorders, the adhesions and complications are all more marked and requires manipulation, careful and painstaking toilet.

In hysterectomy we are divided into two camps, some practicing the super-vaginal amputation, with the extra peritoneal fixation of the stump which gives the best results; others practice complete extirpation or amputation by the flap methods and dropping the stump; the mortality in both operations remains high, but there are some operators working with a low mortality by the extirpation method. The surgery of hard tumors is not so serious and difficult as heretofore imagined. It is true there is a great deal of surgery in the removal of a large fibroid, but if healthy and non-adherent it is a safe and easy operation. The removal of a healthy tumor from a healthy peritoneal cavity, the pedicle made small and fixed in the lower angle of the incision, is one of the safest of major operations. Some of the large, complicated tumors require incision and retraction of the capsule anteriorly.

Small tumors are just as dangerous as large ones in a majority of cases. In the first place, if they are left alone they often become big, and in the second place, the shape of the tumor often does more to determine its dangerousness than mere size. In fibroid tumors of the uterus fantastic features in shape are often present, and the irregularity of contour may cause a comparatively small tumor to encroach in this direction or that upon organs which, if it were symmetrical, would not be interfered with at all. Shape, then, is a great determining feature in the ease or difficulty with which a fibroid growth may be removed. If it is irregular its irregularlty will give less trouble when it is small than when its size is considerable. In addition to this, it is a feature that runs into time and extent of operation. It is rather surprising now to note the frequency with which fibroid tumors occur, and these of a dangerous type. It is surprising how many of these tumors are found among the better classes, where for a long time the woman will suffer in silence and finally only disclose her trouble after the growth is considerable. Here, too, the tumor itself often is not regarded, only the mischief it has caused. Œdema, pain, pressure upon the bladder or intestines or upon the diaphragm, may, alone or together, have rendered life miserable, and the poor sufferer is no longer able to hide her pain and discomfort. What I wish here to insist upon is that in this respect so far as causing complications is concerned—the small tumor is just as apt to figure as a determining factor as the large. If the tumor is a regular, symmetrical one the compli-

cations are apt to come on late; if it is small and nodular, irregularly filling up the pelvis and abdomen, the complications grow apace with its irregularity and the bias of its nodosities, and there is no saying when the symptoms may become suddenly urgent. Combined hard and soft tumors are by no means rare. They are apt to give rise to a good deal of difficulty in diagnosis. Fluctuation may not be present in the fluid portion, but only a peculiar resiliency, while the hard mass in connection with the elastic one may simulate to some extent a pregnancy. Indeed, here we come to a real condition, not a theory. In many cases where the Porro operation is indicated this is the very state of things found. We have a hard tumor or a number of them blocking up the pelvis or extending above the pelvic brim, thus interfering with the delivery of the child. If the woman has gone on to quickening the complication can be readily recognized; but if in the early months, or with a dead fetus, we are put to our wits' end to explain the situation, especially if the tumor has been of rapid growth, concomitant with pregnancy, and never before noticed. In such cases the minutest history must be gotten, and this, in connection with all subjective and objective signs, help us to a diagnosis.

One of the most common complications to be expected with fibroid growths is the dermoid cyst. This peculiar tumor is always an unpleasant complication of any condition alongside of which it may be found. It is uncertain in its nature, painful in character, apt to be complicated in its adhesions, its contents irritating, sometimes offensive; when this is the case the utmost caution must be used to avoid infection.

Tubal disease in the presence of fibroids is most common. This is to be taken into consideration when it is argued that a fibroid can be treated *per se* without resort to surgery. Now, in relation with all fibroids identical tubal disease does not occur. There may be simple inflammatory disease, or there may be hydro-salpinx, or there may be a true pus tube, or a combination of any two of these. What we are to remember—and this cannot be too strongly insisted upon—is that the danger of the existing complications may be paramount, in its way, to the danger of the fibroid itself. None of these tubal condions, with all that this implies, are remediable save by direct interference, as the surgeon finds them. As to what the theorist has to say about them I do not much care.

All fibroid growths are to be watched carefully for malignancy. This is not to be lost sight of under any circumstances. If we attempt to lull ourselves into repose by imagining a tumor entirely benign, we shall often be deceived in the sequence.

Another complication of the fibroid is the irreducible ovarian cyst. Here we may infer that the two masses are one, and, if the error is not early corrected, we shall have the serious misfortune before us of at temping to include an ovarian cyst and a fibroid tumor in one neud. I have in mind a neophyte who, after seeing a fibroid removed by the extraperitoneal method, a day after followed the same technique with an ovarian cyst! Such is the demonstration of surgery to too many lookers-on.

Another altogether different condition, which may puzzle the acutest diagnostician, is a tumor of the kidney crowding itself down upon the uterus. Here the commonest manifestations of fibroid tumor of the uterus are present edema, emaciation, irregular bleeding from the weakened condition of the patient. The uterus cannot be separated from the tumor, and on combined palpation resists and falls with it. In such a condition it is easy to see how any lack of surgical resource is fatal to both patient and operator, and how different is the condition to be dealt with from what has been anticipated.

Bearing in mind the rapidity with which some forms of myomata develop, it is again evident that a thick-walled ectopic sac may simulate one of these tumors.

As I have already said, there has not been, and there is not yet, a consensus of opinion in reference to the best method of removing these growths. The objections to the clamp—the instrument that has given us the best results—are, I consider, puerile. The ideal method is that which gives the best results, aside from the inherent beauty of its conception and execution.

Of the many operations and modifications proposed for the removal of the fibroid uterus, there is need of here considering but three—to wit, the operation by the clamp or serre-neud; the operation for the removal of the entire uterus; and that of stitching the peritoneum across from side to side, leaving the crevix open

in order to allow the escape of pus and ligatures in a few days. Of this latter operation it is only fair to say that the results have been apparently good, but that it is good surgery, or more ideal than the use of the clamp, to do an operation with the expectation of pus to escape from the vagina, is not at all to my understanding.

As to drugs, the growth of tumors is not affected by their use, electricity aggravates them, complicates symptoms, multiplies the difficulties and augments the risks of surgical procedure.

From my experience I feel the importance of urging promptitude in all abdominal and pelvic troubles; of early ovariotomy; of educating the entire profession up to the importance of early recognition and early removal of cystoma; of the early removal of the appendages for fibroid growths; early removal of large and rapidly growing hard tumors, of tubal pregnancy rupturedor unruptured; the early removal of all suppurating forms of tubal and ovarian disease,—*actual, not fancied disease.*

It is important that every member of the general profession in active practice should be able to recognize any and all these troubles. When such becomes a fact of the profession at large an innumerable number of women will be saved untold, unguessed affliction and misery. We have a large and constantly enlarging *need* and the *field* of *work* is *immense*, and the *energy* and *industry* with which it is cultivated should be *correspondingly immense.*

The clinic makes accessible many primary truths and casts a rich light on many difficult problems.

As for myself, so supremely, so profoundly do I feel the great importance of our work, its far-reaching concern, that I would rather by continuous, unrelaxing effort crowd into a few year's that mastery which would crown my work with something prophetic, at least, of its possibilities; a crown into which I would have threaded the lesson that our skill, our refinements and our successes must come of intelligent, tireless application, unselfish devotion and generous co-operation; this, rather than a century of human existence tinkering with the afflictions of the mothers of our race. And in this I am happy in the consciousness that the hearts of many of the Fellows of my Profession beat time with mine.